TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
St Lukes Patients Hospital

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-17-2576-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
May 1, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier originally paid $6379.17. I sent an appeal in due to under payment and they denied additional reimbursement. …Total reimbursement should be $8607.53, paid $6379.17 leaving a balance due of $2228.36."

Amount in Dispute: $2,228.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent maintains its position that $6,379.17 is appropriate in accordance with the Texas Workers' Compensation Fee Schedule, and that Requestor is not entitled to an additional payment of $2,228.36."

Response Submitted by: Brown Sims 1177 West Loop South, Tenth Floor, Houston, Texas 77027

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 5 – 6, 2017	Outpatient hospital services	$2,228.36	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for services provided in an outpatient setting.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 370 – This hospital outpatient allowance was calculated according to the APC rate plus a markup

- 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. What is the applicable rule that pertains to reimbursement?
2. How is the maximum allowable reimbursement calculated?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requester seeks additional reimbursement for $2,228.36 for outpatient hospital services rendered January 5 – 6, 2017.

   The insurance carrier reduced the disputed services with reduction codes, 370 – "This hospital outpatient allowance was calculated according to the APC rate plus a markup," P12 – "Workers compensation jurisdictional fee schedule adjustment," and 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

   These outpatient hospital services are subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part,

   > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided...

   The applicable Medicare payment policy is found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

   The resources that define the components used to calculate the Medicare payment for OPPS are:

   - **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,
     - *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*

   - **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum, D1.

- **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.
- **Composite** - Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, **CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code**.

These payment policies are discussed below in the calculation of the maximum allowable reimbursement.

2. The Division rule pertaining to the calculation of fees for outpatient hospital services is found in 28 Texas Administrative Code §134.403 (f) which states in pertinent part,

> The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
>
> > (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
> >
> > (A) 200 percent;

The reimbursement calculations is as follows:

Procedure Code	APC	Status Indicator	Ranking	Payment Rate	60% labor related	2017 Wage Index Adjustment for provider 0.8679	40% non-labor related	Payment
49505	5341	J1	1,250	*See below*				
49585	5341	J1	1,256	*See below*				
55520	5374	J1	1,283	$2,542.56	$2,542.56 x 60% = $1,525.54	$1,525.54 x 0.8679 = $1,324.02	$2,542.56 x 40% = $1,017.02	$1,324.02 + $1,017.02 = $2,341.04 x 200% = $4,682.08
							Total	$4,682.08

The Medicare Claims Processing Manual found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf states in pertinent part;

***10.2.3 - Comprehensive APCs**, (Rev. 3425, Issued: 12-18-15, Effective: 01-01-16, Implementation: 01-04-16)*

Comprehensive APCs provide a single payment for a primary service, and payment for all adjunctive services reported on the same claim is packaged into payment for the primary service. With few exceptions, all other services reported on a hospital outpatient claim in combination with the primary service are considered to be related to the delivery of the primary service and packaged into the single payment for the primary service.

HCPCS codes assigned to comprehensive APCs are designated with status indicator J1, See Addendum B at www.cms.hhs.gov/HospitalOutpatientPPS/ for the list of HCPCS codes designated with status indicator J1.

*Claims reporting at least one J1 procedure code **will package** the following items and services that are not typically packaged under the OPPS:*

- *major OPPS procedure codes (status indicators P, S, T, V)*
- ***lower ranked comprehensive procedure codes (status indicator J1)***
- *non-pass-through drugs and biologicals (status indicator K)*
- *blood products (status indicator R)*
- *DME (status indicator Y)*
- *therapy services (HCPCS codes with status indicator A reported on therapy revenue centers)*

The single payment for a comprehensive claim is based on the rate associated with either the J1 service or the specific combination of J2 services. ***When multiple J1 services are reported on the same claim, the single payment is based on the rate associated with the highest ranking J1 service.*** *When certain pairs of J1 services (or in certain cases a J1 service and an add-on code) are reported on the same claim, the claim is eligible for a complexity adjustment, which provides a single payment for the claim based on the rate of the next higher comprehensive APC within the same clinical family.*

As shown above the highest ranking code per 2017 Final OPPS, Addendum J, Rank for Primary Assignment found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS is Code 55520.

Review of the Complexity Adjustment Evaluation of Addendum J, finds this service does not qualify for a complexity adjustment. Therefore, the single payment amount shown is for the entire claim based on the applicable APC payment rate as stated in the above Medicare payment policy.

3. The total recommended reimbursement for the disputed services is $4,682.08. The insurance carrier has paid $6,379.17 leaving an amount due to the requestor of $0.00. Additional payment is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 26, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.